

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10672 CERTIFICATE OF DEATH

10672
Reg. Dist. No. 166

1. PLACE OF DEATH o. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND	c. LENGTH OF STAY IN 1b RURAL	b. COUNTY GARRETT	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EVANS NURSING HOME		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELLEN	First JANE	Middle Ash.	Last
4. DATE OF DEATH OCT. 23 1957	Month	Day	Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH APRIL-3-1882
9. AGE (In years lost birthday) 75 yrs.	10. IF UNDER 1 YEAR <input type="checkbox"/>	11. IF UNDER 24 HRS. <input type="checkbox"/>	12. IF UNDER 24 HRS. <input type="checkbox"/>
Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) SPRINGS PA.		11. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN BENDER		14. MOTHER'S MAIDEN NAME HULDA GLASS.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT ROBERT Ash		Address OAKLAND MD PK	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vasular Accident			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Stroke			
DUE TO (b) Diabetes			
DUE TO (c) Arteriosclerosis			
INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Stroke			
3 mos 1950			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 308 2nd St. OAKLAND MD		20f. (City or town) OAKLAND (County) MD (State) MD	
21. I certify that I attended the deceased from 3-23-1957 to 10-20-1957 , that I last saw the deceased alive on Oct. 20 1957 , and that death occurred at 11 P.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 308 2nd St. OAKLAND MD			
DATE SIGNED Jan 4 1958			
ACTUAL SIGNATURE Emray Bolden		PHYSICIAN'S NAME (Type) Emray Bolden	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT-27-1957	
22c. NAME OF CEMETERY OR CREMATORIUM GLADES CEMETERY		22d. LOCATION (City, town, or county) NEAR BITTINGER MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Emray Bolden		ADDRESS OAKLAND MD	
24a. RECD. BY REGISTRAR OCT 27 1957		24b. REGISTRAR'S SIGNATURE Emray Bolden	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
CERTIFICATE OF DEATH

BUREAU V. S.

OCT 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10673

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10673
Reg. Dist. No. 166

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL SWANTON		b. COUNTY GARRETT	
c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL SWANTON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) LEVI MARTIN BITTINGER		4. DATE OF DEATH Month OCT Day 27 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH APRIL 1, 1884
		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Woods		10b. KIND OF BUSINESS OR INDUSTRY CUTTING POSTS	
11. BIRTHPLACE (State or foreign country) GARRETT Co, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LEVI BITTINGER		14. MOTHER'S MAIDEN NAME REBECCA BITTINGER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-18-4813	
		17. INFORMANT Robert Bittinger, Swanton Rd #2 Mo	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction			
DUE TO (b) Sclerotic Heart Disease			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
481 had a 21st for past week			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> ; Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE JAMES H. FEASTER, JR.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> 4 Acting DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 10-27-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-30-57	
22c. NAME OF CEMETERY OR CREMATORIUM LAUREL HILL MOSCOW		22d. LOCATION (City, town or locality) ALLEGHENY (State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE Donald J. Newman - Grantsville MD		ADDRESS NOV 1 1957	
		24a. RECEIVED BY REGISTRAR Julia Rowan	
		24b. REGISTRAR'S SIGNATURE E.T.	

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

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BUREAU OF INVESTIGATION

NOV 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
the page should be detached for use as the Burial-Transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

10674

CERTIFICATE OF DEATH

10674
6

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD		b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ACCIDENT		c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X ACCIDENT MD		d. STREET ADDRESS /			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First MARVIN	Middle GEN	Last CALLIS	4. DATE OF DEATH	Month OCT	Day 17	Year 1957	
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH OCT 11 1907	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most or working life, even if retired) SCHOOL TEACHER		10b. KIND OF BUSINESS OR INDUSTRY NORTHERN HIGH		11. BIRTHPLACE (State or foreign country) ACCIDENT, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME FRANK CALLIS				14. MOTHER'S MAIDEN NAME JANE BOWMAN					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-38-5979		17. INFORMANT Mrs. Lena Callis, Accident, Md		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO (Coronary Occlusion)				INTERVAL BETWEEN ONSET AND DEATH 10 min			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. { (b)		DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 25 ALDER ST		20f. (City or town) OAKLAND		(County) MD	
21. I certify that I attended the deceased from 10/17/57 , 19, to 10/17/57 , 19, that I last saw the deceased alive on 10/17/57 , 19, and that death occurred at 245 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE E.L. BAUMGARTNER						ADDRESS (Street, city or town, state) OAKLAND MD		DATE SIGNED 10/17/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT. 20, 57		22c. NAME OF CEMETERY OR CREMATORIUM BEAR CREEK		22d. LOCATION (City, town, or county) ACCIDENT GARRETT CO MD		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Donald J. Newman		ADDRESS Frontonville Md		24a. RECD BY REGISTRAR 10/20/57 Julie Rowan Pg		24b. REGISTRAR'S SIGNATURE Julie Rowan Pg			

CERTIFICATE OF DEATH

BUREAU V. S.

OCT 09 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10675

CERTIFICATE OF DEATH

106786

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>GARRETT</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>OKHLAND MD</i>	c. LENGTH OF STAY IN lb <i>1 1/2</i>	b. COUNTY <i>GARRETT</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RURAL ACCIDENT XI</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>CUPPETT NURSING HOME</i>		d. STREET ADDRESS <i>/</i>		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>EMMA</i>	Middle <i></i>	Last <i>DEWITT</i>	
4. DATE OF DEATH	Month <i>OCT</i>	Day <i>25</i>	Year <i>1957</i>	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MAR. 15, 1861</i>	
9. AGE (In years last birthday) <i>96 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. IF UNDER 24 HRS. Hours <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>OWN Home</i>	11. BIRTHPLACE (State or foreign country) <i>ACCIDENT, MD</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>SOLOMON BOYER</i>	14. MOTHER'S MAIDEN NAME <i>SALLY MEES</i>	Address <i>Whitfield McAllister, McHenry, Md</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i></i>	17. INFORMANT <i></i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CONGESTIVE HEART FAILURE</i> DUE TO <i>422.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>ARTERIOCLEROTIC CAN DISEASE</i> DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH <i></i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>NOV 1 1956</i> to <i>OCT 25 1957</i> , that I last saw the deceased alive on <i>OCT 15 1957</i> , and that death occurred at <i>12:20 PM</i> , from the causes and on the date stated above.	ADDRESS (Street, city or town, state) <i>25 ALDER ST</i>	DATE SIGNED <i>10/28/57</i>		
ACTUAL SIGNATURE <i>E.I. BAUMGARTNER</i>	PHYSICIAN'S NAME (Type) <i>E.I. BAUMGARTNER</i>	22d. LOCATION (City, town, or county) (State) <i>HAYES GARRETT Co, MD</i>		
22e. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22f. DATE THEREOF <i>10/27/57</i>	22g. NAME OF CEMETERY OR CREMATORIUM <i>HAYES METHODIST</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Donald J. Newman, Grantsville, MD</i>	ADDRESS <i></i>	24a. REC'D BY REGISTRAR DATE <i>10/27/57</i>	24b. REGISTRAR'S SIGNATURE <i>Leah Rowan</i>	

DEPARTMENT OF DEFENSE
CERTIFICATE OF DEATH

BUREAU V. S.

NOV 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10676

CERTIFICATE OF DEATH

10676 6

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Deer Park		c. LENGTH OF STAY IN 1b 43 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Deer Park				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2 1/2 Mi. So. Deer Park, Md.				d. STREET ADDRESS R. D. Deer Park, Md.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Coy		First	Middle	Last	4. DATE OF DEATH October	Month	Day	Year
5. SEX Male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH April 7, 1894	9. AGE (in years less birthday) 63	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer & Farmer, cutting timber in woods		10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Isaac Ervin		14. MOTHER'S MAIDEN NAME Sarah Jane Kitzmiller						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-10-2994		17. INFORMANT Victor Ervin		Address Deer Park, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Myocardial fibrillation						INTERVAL BETWEEN ONSET AND DEATH 6 years		
(b) DUE TO Myocardial heart disease						6 yrs		
(c) Arteriosclerosis						5 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Oakland		20f. (City or town) Oakland	(County) Md.	(State) Md.
21. I certify that I attended the deceased from Jan 3 , 1955 to Oct 24 , 1957, that I last saw the deceased alive on Oct 21 , 1957, and that death occurred at 1:30 A.M. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) Oakland, Md.								
DATE SIGNED 26 Oct 57								
ACTUAL SIGNATURE A. E. Mance, M.D.		M.D.						
PHYSICIAN'S NAME (Type) A. E. Mance, M.D.				Oakland, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/27/1957		22c. NAME OF CEMETERY OR CREMATORIUM Paugh Cemetery		22d. LOCATION (City, town, or county) 2 1/2 Mi. S. Deer Park, Md.		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. L. Leighton		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR 10/27/57		24b. REGISTRAR'S SIGNATURE Julian J. Rowan, Jr.		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

STATE OF CALIFORNIA - DIVISION OF
DEPARTMENT OF STATE

CERTIFICATE OF DEATH

BUREAU V. S.
RECEIVED
OCT 29 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10677	166		
Item 9 747-21 20-23-7 et										CERTIFICATE OF DEATH			
										Reg. Dist. No.			
1. PLACE OF DEATH a. COUNTY										2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
GARRETT MARYLAND										a. STATE	WEST VIRGINIA		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND										b. COUNTY	PRESTON		
c. LENGTH OF STAY IN 1b 1 DAY										c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) AURORA			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL										d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year					
FRONIE		AMELIS	FINT		OCTOBER	13	19	57					
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS						
FEMALE		WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	DECEMBER 18, 81	79 75 yrs.	Months	Days	Hours					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE										12. CITIZEN OF WHAT COUNTRY?			
10b. KIND OF BUSINESS OR INDUSTRY										RED OAK, MD.			
11. BIRTHPLACE (State or foreign country)													
13. FATHER'S NAME JOHN THOMAS CROWE										14. MOTHER'S MAIDEN NAME MARTHA ARONHALT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)										16. SOCIAL SECURITY NO			
17. INFORMANT										Address			
										"HUSBAND" DANIEL LUTHER FINT, AURORA, W.VA.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]										INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33IX Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) DUE TO DUE TO (c)										Cerebral Hemorrhage 30 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										Hypertension Cerebro-vascular Disease 6 years Arterio-sclerosis 10 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.										20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>57</u> , to <u>13 Oct</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12 Oct</u> , 19 <u>57</u> , and that death occurred at <u>7:45 AM</u> , from the causes and on the date stated above.										ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE <u>Andrew E. Mance</u> M.D.										DATE SIGNED <u>13 Oct 57</u>			
PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M. D.										OAKLAND, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)					
Burial		Oct. 15, 1957		Aurora		Aurora		W. Va.					
23. FUNERAL DIRECTOR'S SIGNATURE													
ADDRESS <u>Wayne C. Spiggle Davis, W. Va.</u>													
24a. REG'D BY REGISTRAR DATE <u>10/15/57</u>													
24b. REGISTRAR'S SIGNATURE <u>Jesse Rowan</u>													

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY GARRETT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE MARYLAND		b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 18 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROUTE 1, OAKLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS BOX 163		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ETHEL	Middle MARIE	Last GILSON	4. DATE OF DEATH	Month OCTOBER	Day 17,	Year 1957
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH MAY 29, 1902	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months 55	IF UNDER 24 HRS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) DEER PARK, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GUY W. GILSON		14. MOTHER'S MAIDEN NAME BROOKS, CINDRELLA		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN		16. SOCIAL SECURITY NO		17. INFORMANT "SELF"			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		<i>Uremia + Hydrocephrosis</i>				INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171X		<i>Carcinoma of Cervix uteri</i>				INTERVAL BETWEEN ONSET AND DEATH 2 years	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)							
DUE TO DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to OCT. 17, 1957, that I last saw the deceased alive on OCT. 17, 1957, and that death occurred at 12:10 A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>77 Oak St. Oakland, Md. 10 Oct 57</i>	
ACTUAL SIGNATURE <i>Herbert H. Leighton</i>		DATE SIGNED <i>10 Oct 57</i>					
PHYSICIAN'S NAME (Type) HERBERT H. LEIGHTON, M.D.		OAKLAND, MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 20-57		22c. NAME OF CEMETERY OR CREMATORIUM Deer Park		22d. LOCATION (City, town, or county) Deer Park, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Emory Holden</i>		ADDRESS OAKLAND MD.		24a. REG'D BY REGISTRAR 10/20/57		24b. REGISTRAR'S SIGNATURE <i>J. E. Rawson</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10679	66	
10679 CERTIFICATE OF DEATH										Reg. Dist. No.		
1. PLACE OF DEATH a. COUNTY GARRETT					2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-KITZMILLER							
d. NAME OF HOSPITAL (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL					d. STREET ADDRESS STAR ROUTE - PEERLESS					e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First BIRDIE	Middle BLANCHE	Last HARVEY	4. DATE OF DEATH	Month OCTOBER	Day 23	Year 19 57				
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.					
F		W	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	AUG. 2, 1875	82 yrs. Months	Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE					10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME CHARLES WILSON					14. MOTHER'S MAIDEN NAME MELISSA ELIZABETH WEBB							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO NONE		17. INFORMANT MARTHA E. WEYANT		Address AKRON, OHIO					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i>										2 hrs.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>RT Lobar (basal) pneumonia</i>										3 days		
DUE TO (c) <i>Arteriosclerosis</i>										10 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 470X										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) OAKLAND, MD.	(County) OAKLAND, MD.	(State) MARYLAND			
21. I certify that I attended the deceased from 10/21/57 , to 23 Oct 1957 , that I last saw the deceased alive on 23 Oct 1957 , and that death occurred at 4:00 P.M. from the causes and on the date stated above.										ADDRESS (Street, city or town, state) OAKLAND, MD.		
ACTUAL SIGNATURE <i>Andrew E. Mance</i>										DATE SIGNED 24 Oct 1957		
PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M.D.												
22a. BURIAL, CREMATION, BURNT (Specify)		22b. DATE THEREOF 10/26/57		22c. NAME OF CEMETERY OR CREMATORIUM I.O.O.F. Cemetery			22d. LOCATION (City, town, or county) Elk Garden, W. Va.			(State)		
23. FUNERAL DIRECTOR'S SIGNATURE O. J. Sharfless										ADDRESS Blaine, W. Va.		
24a. RECEIVED BY REGISTRAR 10/26/57										24b. REGISTRAR'S SIGNATURE Julia C. Roman		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nikep					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Robert		First C.	Middle Kiddy	Lost Kiddy	4. DATE OF DEATH October 4 1957	Month October	Day 4	Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH November 12, 1884	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (State or foreign country) Pekin, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Robert Kiddy		14. MOTHER'S MAIDEN NAME Jane Clayton							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Lettie Kiddy		Address Nikep, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		"Wife" Central Nervous Accident Hypertension		INTERVAL BETWEEN ONSET AND DEATH 2 mo					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 25 Academy St		20f. (City or town) Moscow		(County) Md.	(State) Md.
21. I certify that I attended the deceased from Sept 30 , 1957, to October 4, 1957 that I last saw the deceased alive on Oct 1, 1957 , and that death occurred at 1145 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE E. L. Baumgartner		M.D.		ADDRESS (Street, city or town, state) 25 Academy St					DATE SIGNED Oct 6 1957
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/7/57		22c. NAME OF CEMETERY OR CREMATORIAL Laurel Hill Cemetery		22d. LOCATION (City, town, or county) Moscow		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lenacening, Md.		24a. REC'D. BY REGISTRAR 10/7/57		24b. REGISTRAR'S SIGNATURE Julia Mowen			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10681

CERTIFICATE OF DEATH

10681
166

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN lb 35 yrs.		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Oakland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION lith St.		e. STREET ADDRESS 4th St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Donna	Middle Hanna	Last Littman	4. DATE OF DEATH October 28,	Month Year 1957
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 21, 1899	9. AGE (in years at death/birth) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 0 0 0 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife & retired		10b. KIND OF BUSINESS OR INDUSTRY School Teacher		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Walter Hanna		14. MOTHER'S MAIDEN NAME Ella Donaldson		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Julius B. Littman	
				Address Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Paresis, Paraplegia</i>				INTERVAL BETWEEN ONSET AND DEATH 3 hrs	
+ Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		DUE TO (b) <i>Chronic muscular atrophy</i>		4 yrs	
		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct 25</i> , 1957, to <i>Oct 28</i> , 1957, that I last saw the deceased alive on <i>Oct 25</i> , 1957, and that death occurred at <i>4:30 P.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Oakland, Md.</i> DATE SIGNED <i>10/30/57</i>	
MEDICAL CERTIFICATION ACTUAL SIGNATURE <i>E. I. Baumgartner</i>					
PHYSICIAN'S NAME (Type) E. I. Baumgartner, M.D.		Oakland, Md.			
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 10/31/1957		22c. NAME OF CEMETERY OR CREMATORIUM Oakland Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Leighton</i>		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE 10/31/57	
				24b. REGISTRAR'S SIGNATURE <i>Judah S. Rosen</i>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; page may be signed by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10682 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10682

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be sent to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY GARRETT		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY COUNTY		
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FRIENDSVILLE, MARYLAND				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF (Type or print)		First LAWRENCE	Middle RAY	Last MC COMBIE	4. DATE OF DEATH OCTOBER 10 1957	Month OCTOBER	Day 10	Year 1957		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-24-58	9. AGE (In years last birthday) 9 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Shreveport, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME ALBERT LAWRENCE MC COMBIE		14. MOTHER'S MAIDEN NAME GLADYS MAE SHIPP								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT " GLADYS M MC COMBIE (MOTHER) FRIENDSVILLE, MD.		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 40X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last.		Typhoid Fever				INTERVAL BETWEEN ONSET AND DEATH ?				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)						
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> E. I. Baumgartner										
ACTUAL SIGNATURE E. I. Baumgartner		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) E. I. BAUMGARTNER, M. D.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 12, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Steel Cemetery		22d. LOCATION (City, town, or county) near Friendsville, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Emroy Rollens		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR 9/13/57		24b. REGISTRAR'S SIGNATURE i				

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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10683

CERTIFICATE OF DEATH

Reg. Dist. No.

1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; page 4 may be retained by the hospital or attending physician.
2. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b RURAL and give nearest town XO	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SWANTON	
f. STREET ADDRESS 		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First THOMAS	Middle 	4. DATE OF DEATH MC ROBIE
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/24/72
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANCIS MC ROBIE		14. MOTHER'S MAIDEN NAME LUCY MC ROBIE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. 	
17. INFORMANT MRS JAMES SHAFFER SWANTON MD		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] 44dx PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arterio-sclerotic renal vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 8 years (b) Arterio-sclerotic renal vascular disease DUE TO Bilateral (c) Bilateral DUE TO 8 days			
INTERVAL BETWEEN ONSET AND DEATH 2 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) OAKLAND (County) MARYLAND (State) MD	
21. I certify that I attended the deceased from 9/24/1957 to 10/1/1957 , that I last saw the deceased alive on 10/1/1957 , and that death occurred at 12:55 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Andrew E. Mance		ADDRESS (Street, city or town, state) OAKLAND MD DATE SIGNED 10/1/57	
PHYSICIAN'S NAME (Type) ANDREW E. MANCE			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Oct 1-3 1957	
22c. NAME OF CEMETERY OR CREMATORIUM MC ROBIE CEMETERY		22d. LOCATION (City, town, or county) NEAR SWANTON (State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Baldwin OAKLAND MD		24a. REC'D BY REGISTRAR DATE 10/1/57	
		24b. REGISTRAR'S SIGNATURE Julia E. Powers	

REGEV V. S.

OCT

REGEV

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10684

CERTIFICATE OF DEATH

10684
166

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND	c. LENGTH OF STAY IN 1b WEEKS NURSING HOME	b. COUNTY GARRETT	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WEEKS NURSING HOME		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN	First	Middle	Last
4. DATE OF DEATH OCT. - 1 1957	Month	Day	Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB-9-1879
9. AGE (in years lost birthday) 78 yr	10. IF UNDER 1 YEAR Months 185	11. IF UNDER 24 HRS. Days 00	12. IF UNDER 24 HRS. Hours 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) OAKLAND	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME CONRAD MICHAEL	14. MOTHER'S MAIDEN NAME AMANDA SAUAGE		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO. 216-07-6061	17. INFORMANT ARTHUR MICHAEL	Address 185 00 LANCASHIRE DETROIT MICH.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. ARTERIOSCLEROSIS INTERVAL BETWEEN ONSET AND DEATH 6 day			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) RETURNE RT. FEMUR			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) OAKLAND	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from OCT , 19 56 to OCT , 19 57 , that I last saw the deceased alive on SEPT 30 , 19 57 , and that death occurred at H. A. M. , from the causes and on the date stated above. ACTUAL SIGNATURE E. J. Gardner M.D. ADDRESS (Street, city or town, state) 25 ALDER ST DATE SIGNED 10/1/57			
PHYSICIAN'S NAME (Type) E. J. GARDNER	22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF OCT-3-1957 22c. NAME OF CEMETERY OR CREMATORIUM OAKLAND CEMETERY 22d. LOCATION (City, town, or county) OAKLAND (State) MD.		
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden	ADDRESS OAKLAND MD	24a. REG'D AT REGISTRAR 10/3/57	24b. REGISTRAR'S SIGNATURE Jule G. Powers

TO HOSPITAL ■ ATTENDING PHYSICIAN: Fill in **10** to require that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

AMERICAN
MUSEUM

1957

COLLECTIVE
EXHIBITION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10685

CERTIFICATE OF DEATH

Reg. No. 10685/66

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Swanton		c. LENGTH OF STAY IN lb 82 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Swanton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4 Mi. No. Swanton		e. STREET ADDRESS 4 Mi. No. Swanton		f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Stella	Middle Florence	Last Paugh	4. DATE OF DEATH October 2,	Month Year 1957	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1875	9. AGE (in years last birthday) 82 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elijah Howell				14. MOTHER'S MAIDEN NAME Delilah Milt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Stewart Paugh		Address Swanton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertension, I. br. lation = dilation</i> 3 mos 44xx DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Arteriosclerotic Cond. - Renal Disease</i> 7 years DUE TO (c) <i>Cere. t.</i> 4 years Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 58 2nd St Oakland, Md.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4-23, 1957</i> to <i>9-30, 1957</i> , that I last saw the deceased alive on <i>9-30, 1957</i> , and that death occurred at <i>1:30 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>James H. Feaster Jr.</i> ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) James H. Feaster Jr. DATE SIGNED <i>58 2nd St Oakland, Md. 10-4-57</i>							
22a. BUR. AL. CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 5, 1957		22c. NAME OF CEMETERY OR CREMATORIUM North Glade Cemetery		22d. LOCATION (City, town, or county) near Swanton, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert C. Leighton</i>		ADDRESS Oakland, Md.		24a. RECEIVED BY REGISTRAR DATE 10/5/57		24b. REGISTRAR'S SIGNATURE <i>Julia G. Rowan</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tranish permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

OCT 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10686

CERTIFICATE OF DEATH

1068666

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE WEST VIRGINIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 5 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CORINTH	
3. NAME OF DECEASED (Type or print) HARRY		First HARRY	Middle WALTER
4. DATE OF DEATH OCTOBER 12, 1957		Last PHILLIPS	Month Day Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/7/81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAILROAD		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB PHILLIPS		14. MOTHER'S MAIDEN NAME UNKNOWN <i>Ella Poling</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO 234-12-0565	
17. INFORMANT DAUGHTER (MRS. PEARL FREELAND)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1		<i>Atelectasis, Pneumonitis, right lung</i> 6 days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first b.		<i>Cerebral Vascular Accident</i> 2 mos.	
DUE TO c.		<i>Atherosclerotic Cardiovascular Disease</i> 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 77 OAK STREET
20f. (City or town) OAKLAND, MARYLAND		(County) M.D. (State) MARYLAND	
21. I certify that I attended the deceased from 10/8 , 1957, to 10/12 , 1957, that I last saw the deceased alive on 10/12 , 1957, and that death occurred at 1:10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Herbert H. Leighton</i>		ADDRESS (Street, city or town, state) 77 OAK STREET	
PHYSICIAN'S NAME (Type) HERBERT H. LEIGHTON, M.D.		DATE SIGNED OCTOBER 12, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal 1434-12		22b. DATE THEREOF 12/14/57	
22c. NAME OF CEMETERY OR CREMATORIUM Knight of Pythias Cemetery Newburg, West Virginia		22d. LOCATION (City, town, or county) (State) Newburg, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE <i>E. M. Watson</i>		ADDRESS Terra Alta	
24a. REC'D BY REGISTRAR 12/14/57		24b. REGISTRAR'S SIGNATURE <i>Judith Noway</i>	

EUREKA Y, 2

OCT 17 1957

REGELIVEL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10687			
CERTIFICATE OF DEATH										Reg. Dist. No. 666			
1. PLACE OF DEATH a. COUNTY GARRETT					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND					c. LENGTH OF STAY IN lb 3 days					b. COUNTY GARRETT			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL					d. STREET ADDRESS MT. LAKE PARK, MARYLAND					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First MAURICE	Middle L.	Last SISK	4. DATE OF DEATH OCTOBER	Month OCTOBER	Day 11	Year 1957					
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 10/22/75	9. AGE (In years at birthday) 81 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam Engin tender for Balto. & Ohio R R Co		10b. KIND OF BUSINESS OR INDUSTRY DEER PARK, MARYLAND		11. BIRTHPLACE (State or foreign country) DEER PARK, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME HENRY, SISK				14. MOTHER'S MAIDEN NAME DELLA SPENCER									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO 705-12-3273		17. INFORMANT Mrs. D. E. Callis		Address Mt. Lake Park, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]										INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonitis										3 days			
4. d.d.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) Cerebral Vascular Accident (c) Atherosclerotic Cardiovascular Disease										5 days 15-20 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m.		Month 10	Day 9	Year 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)				
21. I certify that I attended the deceased from 10/9/1957 to 10/11/1957 , that I last saw the deceased alive on 10/11/1957 , and that death occurred at 10:05 P.M. from the causes and on the date stated above.										ADDRESS (Street, city or town, state) 77 Oak Street, Oakland, Md. DATE SIGNED Oct 11, 1957			
ACTUAL SIGNATURE Herbert H. Leighton M.D.													
PHYSICIAN'S NAME (Type) HERBERT LEIGHTON M.D.										OAKLAND, MARYLAND			
22a. BURIAL, CREMATION, BURIAL (Specify) Burial		22b. DATE THEREOF 10/11/1957		22c. NAME OF CEMETERY OR CREMATORIUM Oakland Cemetery			22d. LOCATION (City, town, or county) Oakland, Md.			(State)			
23. FUNERAL DIRECTOR'S SIGNATURE H.C. Leighton		ADDRESS Oaklan d, Md.		24a. REC'D. BY REGISTRAR 10/14/57			24b. REGISTRAR'S SIGNATURE Debra G. Rowan						

REAU V. R.

OCT 17 1957

REGEV EDO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10688

CERTIFICATE OF DEATH

10688
6

Reg. Dist. No.

1. PLACE OF DEATH o. COUNT GARRETT		MARYLAND	2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) o STATE MARYLAND		b. COUNTY GARRETT					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 3 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL SWANTON							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS ROUTE #1	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	Brenda Kay	Middle TICHINEL	4. DATE OF DEATH OCTOBER	Month 1	Day 19	Year 57				
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 29, 1957	9. AGE (in years from birthday) yrs. 3	IF UNDER 1 YEAR Months 3	IF UNDER 24 HRS. Days Hours Min				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? AMERICA				
13. FATHER'S NAME TICHINEL, JAMES		14. MOTHER'S MAIDEN NAME JOYCE, JUANITA VIRGINIA		Address						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT James Tichinel, R#1, Swanton, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MULTIPLE CONGENITAL ANOMALIES DUE TO Bilateral Harelip, cleft Palate, Conditions, if any, which gave rise to immediate cause (a), listing the under- lying cause first. (b) Encephalitis and DUE TO Polydactylism (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 58 2nd st Oakland, Md.	(County) OAKLAND	(State) MARYLAND	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that I attended the deceased from 9/29, 1957, to 10/1, 1957, that I last saw the deceased alive on 10/1, 1957, and that death occurred at 12:55 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE James H. McMaster, Jr. M. D.		ADDRESS (Street, city or town, state) OAKLAND, MARYLAND		DATE SIGNED 10-2-57						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 2/57	22c. NAME OF CEMETERY OR CREMATORIUM Turner Cemetery	22d. LOCATION (City, town, or county) R#1, Swanton, Md.		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE O. H. Sharpleas		ADDRESS Blaine, W. Va.	24a. REC'D BY REGISTRAR 10/2/57 Julie A. Rowan		24b. REGISTRAR'S SIGNATURE J. A. Rowan					
VS A15 (4) 15M 9/55		318 XV4								

REGEVÉ
DET 2 1957

DUPEAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
this page should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10689

CERTIFICATE OF DEATH

10689
166

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - SWANTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS ROUTE # 1	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First KATHLEEN	Middle LENORE	Last TICHNELL
4. DATE OF DEATH	Month OCTOBER	Day 28	Year 1957
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 25, 1905
9. AGE (In years lost birthday) 52 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FREDERICK JUNKINS		14. MOTHER'S MAIDEN NAME MAUDE GRIFFITH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO	
17. INFORMANT ARTHUR TICHNELL - ROUTE # 1 - SWANTON, MARYLAND		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO DUE TO C (c)		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 9, 1957, to OCTOBER 27, 1957, that I last saw the deceased alive on October 27, 1957, and that death occurred at 9:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Andrew E. Mance		ADDRESS (Street, city or town, state) Oakland Rd DATE SIGNED 29 Oct 17	
PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M.D.		OAKLAND, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL Oct. 31, 1957		22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIUM Tichnell Cem.	
22d. LOCATION (Cty, town, or county) GARRETT Co., Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE E. S. Rod Westernport, Md.		24a. REC'D BY REGISTRAR 10/31/57 Julia A. Rowan L.P.	
		24b. REGISTRAR'S SIGNATURE	

BUREAU V. S

NOV 12 1957

1031125 - FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be retained for use as a burial permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH 10690

Reg. Dist. No.

1. PLACE OF DEATH COUNTY GARRETT CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN KITZMILLER		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN KITZMILLER	
HOSPITAL OR INSTITUTION OR STREET ADDRESS E. MAIN STREET		STREET ADDRESS E. MAIN STREET	
3. NAME OF DECEASED (Type or Print) WILLIAM DANIEL WALKER		4. DATE OF DEATH OCTOBER 22, 1957	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH April 23, 1861
9. AGE last birthday 96 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if Mine Forman)		10b. KIND OF BUSINESS OR INDUSTRY Coal Miner	
11. BIRTHPLACE (State or foreign country) Union Co., Georgia		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME JONATHAN CLARK WALKER		14. MOTHER'S MAIDEN NAME ALICE PENLAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no.) No		16. SOCIAL SECURITY NO. 238-26-0520-A	
17. INFORMANT & ADDRESS J.W. WALKER, SHALIMAR, MD.		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <i>Acute Pulmonary Edema</i> ANTECEDENT CAUSE(S) DUE TO <i>Hypertension</i> DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Bilateral digital venous</i>			
INTERVAL BETWEEN ONSET AND DEATH 1 day 2 hrs			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) Kitzmiller, Md	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 19, 1957, to Oct. 22, 1957, that I last saw the deceased alive on Oct. 22, 1957, and that death occurred at 1:15 P.M. from the causes and on the date stated above. SIGNATURE <i>Ralph Calandella</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct. 25/57	
NAME OF CEMETERY OR CREMATORIAL I.O.O.F. Cemetery		LOCATION (City, town, or county) Elk Garden, W. Va.	
24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE Aut Barrick		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Blaine, W. Va.	
DATE 10/24/57		DATE 10/24/57	

BUREAU V.

OCT 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10691 CERTIFICATE OF DEATH

1069166
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park,		b. COUNTY Garrett	
c. LENGTH OF STAY IN 1b 50 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park, <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) F. Street		d. STREET ADDRESS E. Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Laura		First G.	Middle Welch
4. DATE OF DEATH October 18, 1957	Month Oct.	Day 18	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1879
9. AGE (In years from birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Md. Public school	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Sila S Weimer		14. MOTHER'S MAIDEN NAME Nancy Jane McRobie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Joseph H. Welch		Address Mt. Lake Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 744.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) } DUE TO } (c)		INTERVAL BETWEEN ONSET AND DEATH 2 years	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Cardiovascular Disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 5, 1957</u> to <u>Oct. 18, 1957</u> , that I last saw the deceased alive on <u>Oct. 18, 1957</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Herbert H. Leighton</u> M.D. <u>77 Oak St., Oakland, Md.</u> <u>Oct. 20, 1957</u>			
PHYSICIAN'S NAME (Type) Herbert H. Leighton, M. D.		Oakland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/21/1957	22c. NAME OF CEMETERY OR CREMATORIUM Oakland Cemetery
22d. LOCATION (City, town, or county) Oakland, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert H. Leighton</u>		24a. REC'D BY REGISTRAR 10/21/57	24b. REGISTRAR'S SIGNATURE <u>J. Leighton</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF CIVIL
REGISTRATION

BUREAU V.

OCT 29 1957

REGISTRY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 12 Film 0221 10-14-57 et

10692

CERTIFICATE OF DEATH

1069766
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT Co MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND	c. LENGTH OF STAY IN 1b xo	b. COUNTY GARRETT Co	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CUPPETT'S NURSING HOME		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND Co.	
		d. STREET ADDRESS /	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First ELLAZAN	Middle ELIZABETH	Last WINTERS	4. DATE OF DEATH OCT. 6 1957
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH JUNE-13-1869	9. AGE (in years last birthday) 88 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Oakland(rural), Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME SACOB HAUSER	14. MOTHER'S MAIDEN NAME MARGARET Roth	Address RT-1 CARL WINTERS OAKLAND MD
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	INTERVAL BETWEEN ONSET AND DEATH
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arterio Sclerosis	DUE TO 450.0	Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Hypochromic Anemia	DUE TO (c)	
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) hypochromic Anemia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
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20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from Lee , 1957, to Oct , 1957, that I last saw the deceased alive on October 19 57 , and that death occurred at 51 P.M. from the causes and on the date stated above.	ADDRESS (Street, city or town, state) 25 Cedar St Oakland Md	DATE SIGNED 10/7/57
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ACTUAL SIGNATURE E. I. BANISTER	PHYSICIAN'S NAME (Type) E. I. BANISTER	
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22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF OCT-9-1957	22c. NAME OF CEMETERY OR CREMATORIY RED HOUSE CEMETERY	22d. LOCATION (City, town, or county) RED HOUSE	(State) MD
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23. FUNERAL DIRECTOR'S SIGNATURE Emroy Bolden	ADDRESS OAKLAND MD	24a. REC'D BY REGISTRAR 10/9/57 Julie Howard	24b. REGISTRAR'S SIGNATURE X
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MANHATTAN STATE GOVERNMENT OF HAWAII - WAIKIKI, HI

CERTIFICATE OF DATA

RECEIVED ON NOV 2 1957

BUREAU V. S.

OCT 9 1957

RECEIVED